II. REIMBURSEMENT LIMITS

A. Reimbursement for in-state hospital inpatient services provided to Medi-Cal program beneficiaries for provider fiscal periods beginning on or after May 23, 1992 and not fully covered by a negotiated contract as allowed in the Welfare and Institution Code (W&I) Section 14081, shall be the lowest of the following four items except as stated in B., D., F., G., and H., for each provider:

1) Customary charges;

2) Allowable costs determined by the Department, in accordance with applicable Medicare standards and principles of cost based reimbursement, as specified in applicable parts of 42 Code of Federal Regulations (CFR), Part 413 and HCFA Publication 15-1.

3) All-inclusive rate per discharge limitation (ARPDL). This is detailed in Section V. of this Plan.

4) The peer grouping rate per discharge limitation (PGRPDL). This is detailed in Section IX. of this Plan.

B. The following adjustment should be made to items 1) through 4) above:

1) Providers shall also be reimbursed for disproportionate share payments if applicable.

2) The least of the four items listed in A. 1) - 4) above shall be reduced by the amount of TPL.

C. Amounts determined under 3) or 4) above may be increased only by an AA or formal appeal.

D. New hospitals and rural hospitals shall be exempt from the provisions of this part of the Plan relating to the MIRL and PIRL. New and rural hospitals shall be reimbursed in accordance with the lessor of A. 1) or A. 2) above, and subject to any limitations provided for under federal law and/or regulation.

E. Reimbursement for hospital inpatient services provided by State Hospitals under the jurisdiction of the State Department of Developmental Services and Mental Health will be exempt from Section I. through XVI. of this Plan. Payment for services to these providers will be under Medicare retrospective reimbursement principles; audit, administrative and appeal procedures; and applicable cost ceiling limitations.

F. Each provider shall be notified of the ARPDL and PGRPDL at the time of tentative and/or final PIRL settlements. If only a final PIRL settlement is issued, it shall take the place of both the tentative and final PIRL settlement.

G. Payments for Medicare covered services provided to Medicare/Medi-Cal crossover patients shall not be subject to the limitations specified in this part of the Plan. These services shall be reimbursed only for the Medicare deductibles and co-insurance amounts. The deductibles and co-insurance amounts shall not exceed the state reimbursement maximums. State reimbursement maximums shall be the interim rate times Medi-Cal charges after consideration of the Medicare payment.

H. Payment for skilled nursing facility services shall be made in accordance with Section 51511.

I. Payment for intermediate care facility services shall be made in accordance with Section 51510.

J. Hospitals that elect to provide transitional inpatient care services by voluntarily entering into a transitional inpatient care contract will receive a reimbursement rate that is modeled on the distinct-part nursing facility reimbursement rates, and includes increases for components of the transitional inpatient care program that are not part of the distinct-part nursing facility rate. (For details about the payment methodology, refer to Supplement 2 to Attachment 4.19D for the "Study to Determine Rates for Transitional Inpatient Care".)

K. Hospitals that do not elect to voluntarily enter into a transitional inpatient care contract, but are located in a geographic area where a transitional inpatient care contractor(s) exists, may transfer a TC patient to a contract facility. Until the patient is transferred, the hospital will be reimbursed in the same manner and at the same rate as a hospital that has voluntarily entered into a transitional inpatient care contract. This rate is higher than that paid for nursing facility services alone, but lower than the acute inpatient hospital rate.

III. METHODS OF PAYMENT

A. The methods of payment for inpatient hospital services under the MIRL shall include the following:

1) An ARPD that shall be retrospectively established for each provider's tentative and final settlement fiscal period. The ARPD shall:

(a) Apply to all non-contract Medi-Cal inpatient covered services provided by the provider during its settlement fiscal period. It shall be based upon the statistics included in the providers Medi-Cal cost or audit report.

(b) Be updated annually to reflect reimbursable changes in factor input prices, service intensity, technology, productivity, patient volume, and other items as allowed through the AA and appeals process.

2) An interim payment rate based upon an actual or projected reimbursable cost to charge ratio.

(a) The current interim payment rate shall be based on the lower of the following:

1. The latest tentative settlement fiscal period for which a final settlement has not been issued.

2. The latest final (which also includes recalculated finals) settlement fiscal period reimbursable cost-to-allowable customary charge ratio expressed as a percentage, rounded to the nearest whole integer, up or down.

(b) Interim payment rates calculated under A. may use data from settlements that have been previously issued if needed to determine the lower of 1) and 2) above.

(c) When newly-established providers do not have cost experience which to base a determination of an interim rate of payment the Department will use the following methods to determine an appropriate rate:

1. If there is a provider or providers comparable in substantially all relevant factors to the

provider for which the rate is needed, the Department will base an interim rate of payment on the reimbursable costs and customary charges of the comparable provider.

2. If there are no substantially comparable providers from whom data are available, the Department will determine an interim rate of payment based on the budgeted or projected reimbursable costs and customary charges of the provider.

3. Under either method, the Department will review the provider's cost and charge experience and adjust the interim rate of payment in line with the provider's cost and charge experience.

4. The Department may prohibit increases in the accommodation rates, as defined in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1, charged by the provider if the Department projects that such increases would cause their interim payments to exceed the PIRL.

5. Newly established providers may appeal their interim rate if it is based upon the criteria in A. 2) (c) 1. through 4., in accordance with the AAR procedures specified in Section VI. of this Plan.

IV. OVERPAYMENTS

A. Interim payment rate adjustments and recovery of overpayments to providers shall be made at tentative or final settlement based upon the application of this Plan.

1) Such overpayments shall be collected and such interim payment rates shall be adjusted whether or not appeals of any audit, MIRL or PIRL for the current or any prior fiscal period have been filed by the provider.

2) Interim payment rates calculated after May 23, 1992 for Sections I. through XIII. of this Plan and applied to services provided after May 23, 1992, shall comply with Sections III. and IV. of this Plan even if the actual settlement upon which the new interim rate is based, is not subject to the Plan.

B. Within the time specified in 42 CFR 433.316 - 433.320, the State will refund to HCFA the federal share of the provider overpayments, unless the overpayment debt has been discharged in bankruptcy or is otherwise uncollectable as specified in 42 USC Section 1396 b(d) (2) (D).

V. REIMBURSEMENT FORMULA

A. A hospital cost index (HCI) shall be established for each provider. This index shall consist of an input price index (IPI) and shall contain an allowance for changes in scientific and technological advancement; service intensity and productivity. The allowance shall be called the Service Intensity, Productivity, Scientific and Technological Advancement Factor (SIPTF). The HCI shall be calculated:

1) To account for actual changes in the IPI after the close of each provider's accounting period.

2) By multiplying the HCI by the non-pass-through portion of the provider's MIRL reimbursement rate per discharge (tentative or final) for the prior fiscal period to determine the non-pass-through portion of its ARPD for the settlement fiscal period.

B. The prior period shall always be the base period for each settlement.

C. For the initial base period only, the non-pass-through portion of the ARPD shall be calculated as follows:

1) Step 1, add the amount of TPL for the initial base period to the MIRL (lowest of 51536(a)(1)-(3)) which includes amounts reimbursed under the AA and appeals process for the initial base period.

2) Step 2, recalculate Medi-Cal discharges for any initial base period in accordance with the definition of Medi-Cal discharges contained in Section II. of this Plan.

(a) The Department shall notify the provider of the revised count of Medi-Cal discharges for the initial base period.

(b) The provider may file an AAR on the count of Medi-Cal discharges for the initial base period only and only as it is used in the settlement period MIRL. The AAR

must be filed within 60 days of notification of the number of Medi-Cal discharges for the initial base period.

(c) The provider may file an appeal of the Department's response to the AAR in accordance with Section VIII. of this Plan.

3) Step 3, divide the result of step 1 by the result of step 2.

4) Step 4, multiply the percentage of non-pass-through costs for the initial base period by the result of step 3.

5) Use the result of step 4 in place of the PNPARPD in the ARPD formula in D. below.

D. The ARPD shall be calculated as follows:

ARPD = PASPD + NPARPD.
= PASPD + (PNPARPD * HCI)
= (TPTC/THD) + (PNPARPD * ((AIPI * CMAF) + SIPTF))

Where ARPD = All-inclusive Rate Per Discharge.
PASPD = Pass through per discharge = TPTC/THD
TPTC = Total pass through costs in the settlement fiscal period.

THD = Total hospital discharges in the settlement fiscal period.

NPARPD = Non-Pass-through All-inclusive Rate Per Discharge.

NPARPD = PNPARPD * HCI.

PNPARPD = Prior year Non-Pass-through portion of the MIRL reimbursement rate per discharge which is, ((PMIRL - (PMCDIS * (PTPTC/PTHD)))/PMCDIS)

Where:

PMIRL = Prior fiscal period MIRL.
PMCDIS = Prior fiscal period number of Medi-Cal discharges.
PTPTC = Prior fiscal period total pass through costs.
PTHD = Prior fiscal period total hospital discharges

HCI = Hospital Cost Index =

((AIPI) ** (Days/730))* CMAF) + (SIPTF. **(Days/730))

If the prior or settlement fiscal period is long (over 370 days) or short (under 360 days). If both fiscal periods are over 359 days and under 371 days HCI = (AIPI * CMAF) + SIPTF.

Where:

AIPI = Adjusted Input Price Index.

SIPTF = Allowance for Service Intensity, Productivity, and Scientific and Technological Advancement Factor.

Days = Sum of days in the current and prior fiscal periods.

CMAF = Case mix adjustment factor.

* = Multiplication.
** = Exponentiation.

E. An annual allowance for service intensity, productivity and scientific and technological advancement shall be added to the allowable increase in the non-pass-through portion of the ARPD, as detailed in the formulas in this part of the Plan. This allowance shall be in addition to reimbursement for pass-through categories and shall be the net amount of changes for scientific and technological advancement, productivity improvement and service intensity, if any (excluding case mix), as recommended annually by the Prospective Payment Assessment Commission for the Medicare PPS for all FPEs during the PPS effective dates of the recommended allowance.

F. The pass-through categories are those hospital cost categories which, for purposes of tentative and final settlement, are not subject to the HCI.

1) Each pass-through category is listed below:

(a) Depreciation.
(b) Rents and Leases.
(c) Interest.
(d) Property Taxes and License Fees.
(e) Utility Expenses.
(f) Malpractice Insurance.

G. An IPI shall be established to compute the reimbursable change in the prices of goods and services purchased by the providers (except for pass-throughs). The IPI shall consist of a market basket classification of goods and services purchased by providers, a corresponding set of market basket weights derived from each provider's own mix of purchased goods and services, and a related series of price indicators.

H. Weights corresponding to market basket categories shall be derived and updated for each settlement fiscal period. These weights shall be computed using the latest available information from each provider's Medi-Cal cost report. If information from this source is not sufficient to establish a hospital specific weight for a particular market basket category, the Department shall assign a weight based on information from the United States National Hospital Input Price Index published by the Department of Health and Human Services, or other available sources.

I. The IPI shall be calculated after the close of each hospital's FPE, to account for actual and/or estimated changes in the:

1) Hospital specific wage and benefit rates.

(a) The index for allowable increases in wages shall be computed as follows:

Salary and Wage Index (SWI) = CLSA/ACSA.

Where:
CLSA = Summation of (PYHx * CYHRx) for all x.

ACSA = Summation of all Actual Prior Fiscal Period Salaries for all x categories.
x = The following categories:

a. Technicians and Specialists.
b. Registered Nurses.
c. LVNs.
d. Aides and orderlies.
e. Clerical and other administrative.
f. Environmental and food service.

PYHx = Prior Fiscal Period Productive Hours.

CYHRx = Current (Settlement) Fiscal Period Hourly Rate
= CYSx/CYHx.

CYSx = Current (Settlement) Fiscal Period salary Expense for each category.

CYHx = Current (Settlement) Fiscal Period productive Hours.

(b) The Employee Benefits Index (EBI) shall be computed as follows:

EBI = (PYHT X CYBR)/PYB.

Where:

PYHT = Prior Year (Prior Fiscal Period) Paid Labor Hours for All Labor Categories.

CYBR = Current Year (Settlement Fiscal Period) Benefit Rate = CYB/CYHT.

PYB = Prior Year (Prior Fiscal Period) Benefits Costs.

CYB = Current Year (Settlement Fiscal Period) Benefits costs.

CYHT = Current Year (Settlement Fiscal Period) Labor Hours for All Labor Categories.

(c) The SWI and EBI shall be annualized for any provider which has a short or long (under 360 or over 370 days) prior or current fiscal period.

1. The SWI shall be adjusted using the following formula:

ASWI = SWI ** (730/Days).
ASWI = Adjusted SWI.
Where Days = Total days in the current and prior fiscal periods.

2. The EBI shall be adjusted using the following formula:

AEBI = EBI ** (730/Days).
Where:
AEBI = Adjusted EBI.
Days = Total days in the current and prior fiscal periods.

3. If the SWI and EBI are not annualized, then the ASWI = SWI and AEBI = EBI.

2) Price indicators for other non-pass-through categories.

3) Market basket weights for the following categories:
   (a) Salary and wages.
   (b) Benefits.
   (c) Professional fees, medical.
   (d) Professional fees, other.
   (e) Food.
   (f) Drugs.
   (g) All other non-pass-through costs.

4) The non-pass-through costs "all other" category shall be weighted using the following weights for purposes of calculating the price indicator:

Category	Weight
Chemicals	12.16%
Surgical and Medical Instruments and Supplies	10.59%
Rubber and Miscellaneous Plastics	9.02%
Travel	4.71%
Apparel and Textiles	4.31%
Business Services	14.90%
All other miscellaneous	44.31%

5) The weights for the seven market basket categories shall be the percentage of costs for each category as calculated from the Medi-Cal cost report.

6) Each market basket weight shall be multiplied by the corresponding price indicator. The results will be summed to obtain the unadjusted non-pass-through price index.

7) The price indicators for items under I. 3) (c through g) will be established for the end of each calendar quarter (March 31, June 30, September 30 and December 31). Any FPE other than on a calendar quarter shall use the price indicators under 3) above for the quarter in which the provider's FPEs.

   (a) The following five market basket categories and price indicators to be used in developing each provider's IPI are shown in the following table.